MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 23, 2004
10:13 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. DeBUSK
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Work plan for MedPAC's specialty hospital study
-- Julian Pettengill, Carol Carter

MS. CARTER: The MMA asked us to examine specialty hospitals. And what was defined in the law was for us to look at cardiac, orthopedic and surgery hospitals.

The context for this study is the following: specialty hospitals, practically physician-owned hospitals, represent a small but growing share of the hospital industry. GAO reported last year that the number of specialty hospitals had tripled and now number 100. And there were 20 additional ones under development.

Another piece of context is the Stark anti-self-referral law. This law prohibits physicians from referring Medicare patients for certain services to facilities in which they have a financial interest. Hospitals are excluded from this ban. The idea being that an individual physician gains very little from the range of services provided by a hospital.

Lawmakers may have different views and concerns about specialty hospitals. In the MMA, Congress imposed an 18-month moratorium on excluding new hospitals from the Stark self-referral ban. As a result, hospitals are subject to the ban, effectively freezing the development of specialty hospitals.

Congress also requested two studies. HHS was asked to look at referrals and the differences between specialty and community hospitals in the amount of uncompensated care and the quality of care that they provide.

We were asked to look at five areas, hospital costs by DRG and to compare physician-owned and community hospitals costs for the different types of specialty hospitals. We were asked to look as patient selection within a broad category such as heart cases and to compare the mix of cases at specialty and community hospitals. We were asked to look at payer mix and the financial impact of specialty hospitals on community hospitals. And finally, we were asked to determine how the inpatient PPS might be refined to better reflect hospital costs.

Our report is due in February of next year.

In the last several months, we've met with various representatives of specialty and committee hospitals and these are the themes that we've heard. Supporters told us that the development of specialty hospitals is often physician driven. Some physicians want to improve the efficiency of the services and have become frustrated by the barriers they face in making improvements at the hospitals where they practice.

Supporters contend that specialty hospitals focus on the types of cases that they do well and that this concentration has many benefits. For example, they have improved facility designs, staff experienced in treating a specific type of patient and standardized care processes that produce services more efficiently. These features also result in quality of care that is comparable or higher than the care provided at other

hospitals. And these same features also result in higher patient and physician satisfaction.

Some specialty hospitals acknowledge that they do select certain types of patients but contend that this is responsible practice because specialty hospitals have fewer services such as backup capability and consulting physicians on staff. Patients who are likely to need these services are referred elsewhere so that they are not exposed to unnecessary risk by having been admitted to a hospital that cannot handle their complex medical condition.

Supporters noted that some specialty hospitals avoid entering small markets where community hospitals are week. In such situations the community hospital might fail and it would leave the specialty hospital to provide services that they are not ready to take on.

This is what the specialty hospital critics told us. They maintain that the development of specialty hospitals is driven by physicians' desire to raise their incomes. To this end they argue that specialty hospitals select profitable DRGs and within those the uncomplicated lower cost of cases, leaving community hospitals to treat the unprofitable patients.

Critics also note that specialty hospitals are less likely to offer certain services like emergency room and uncompensated care. And because profitable cases were selected and treated at specialty hospitals, community hospitals have diminished financial ability to furnish these services or to afford the kinds of improvements that would make them more like specialty hospitals.

This brings us to our study. Our first task is to define a specialty hospital. Based on the mandate language, we will focus our study on physician-owned hospitals. We will examine cardiac, orthopedic and surgical hospitals. We will base our definition on specialty hospitals on the degree of concentration, that is the share of a hospital's discharges in a single clinical area. Though our definition will be based on looking at the distributions of shares across hospitals, it cannot avoid being somewhat arbitrary.

For comparison hospital groups, as requested in the mandate, we will compare physician-owned specialty hospitals with all community hospitals in their markets. But because this community hospital group is very heterogeneous, we plan to compare physician-owned hospitals with two other groups of hospitals. First, community hospitals that are equally concentrated but not physician-owned. This will allow us to examine equally concentrated hospitals but different in terms of their ownership.

A second group, particularly to examine the impact of specialty hospitals on competitors in their markets, will look at community hospitals in the same market that provide comparable services. These are the hospitals that specialty hospitals most directly compete with.

In different analysis, we plan to look at different comparison groups and, for example, in looking at quality of care and maybe competition we might focus on specific types of

services within even the specialty hospital range of services.

Now Julian will summarize the studies that we have planned.

MR. PETTENGILL: As we described in the mailing, we have analyses planned in six areas identified on this slide. In addition to that, we plan to make site visits to several markets where physician-owned specialty hospitals are located. This site visits will give us the opportunity to interview people in the specialty hospitals and in local community hospitals to better understand the motivations and the dynamics of this phenomenon.

Now what I'd like to do is briefly walk you through the six analytic areas identified here.

Once we have a working definition of a physician-owned specialty hospitals and the comparison groups of community hospitals, we will begin with some descriptive analyses of the characteristics of the specialty hospitals and the markets in which they are located. Hospital characteristics would include things like the number of hospitals, their locations, size, services offered and that sort of thing. We will also have some information on their ownership arrangements and their Medicare and market shares. For the markets we plan to contrast markets with and without specialty hospitals and will be able to assess whether they are rural or urban in character, population characteristics of the people living in the area, and some other features of the market and regulatory environment.

The next topic is patient selection. This part of the study will examine differences in DRG case-mix and severity of illness within DRGs between physician-owned specialty hospitals and the community comparison groups. Most of this analysis will focus on Medicare data, Medicare case-mix and illness severity using claims from the 2002 MedPAR file.

For a few states we may also examine case-mix and severity differences between specialty and community hospitals for the population covered by private payers.

In a third part of the study we will be looking at differences in profitability across DRGs under Medicare's inpatient prospective payment system and we'll also look at whether private payers payment rates appear to follow a similar pattern across DRGs.

For the Medicare inpatient prospective payment system we will use data from the claims and the hospital's cost reports to estimate payments costs and profitability across and within DRGs. For the private payers analysis we will be using the pattern of payments per case in private insurance claims and will compare that with the pattern under Medicare.

If we find substantial differences in profitability in the PPS we will then examine potential refinements to the DRG definitions and to the way the weights are calculated that might make profitability more uniform across DRGs and thereby reducing payment incentives for favorable selection and specialization.

The next part of the study will address the quality of care. And here we'll be looking, to the extent possible, at differences in the quality of care between physician-owned specialty hospitals and our comparison group of our community hospitals. We will use many of the same mortality and patient

safety indicators that the Commission used in its quality chapter of the March report this year. Our ability to find quality differences in this analysis will be limited you understand, of course, because we're likely to have relatively few physician-owned specialty hospitals and correspondingly small number of cases to work with here in which we're trying to find relatively rare events. Kind of a bad combination.

We will also look at differences in length of stay, transfer rates and discharge disposition of patients.

And then, as we were asked to do, we will also examine the effects that specialty hospitals have when they enter the market on beneficiary service use, program spending and, of course, the community hospitals' financial outcomes. Again, our ability to find much here to answer these questions will be limited because most specialty hospitals haven't been around for more than a few years. Consequently, we don't have very much information to work with in terms of cost report data and so forth.

We may be able to take a case study kind of approach in a few markets where specialty hospitals have been around for four or five years and we may have to be satisfied with that because there's simply no other data available.

Another way to get some sense about some of the potential outcomes, at least regarding substitution across sites of service and impact on program spending, is to look at what's happened with the entry of ASCs into markets. The advantage there is that ASCs have been growing rapidly for a long time. They have been around a lot longer and we have much more data to look at. And of course, they are of interest in their own right. That's the one study that Ariel talked about yesterday. So we'll be doing that.

And then finally the last area, we weren't asked specifically to do this, this is something that HHS was asked to do. But it's awful hard to talk about this topic without going into the origins and evolution of the self-referral policy. It's a very important part of the context. It's also one area of policy in which modifications might be made to address the underlying issue of whether specialization of this kind is appropriate and how one might limit it. So we will have an analysis of the origins and evolution of the policy.

We will also have some analysis of other strategies that some of the states have been considering. This would include things like requiring all hospitals to have a staffed emergency room and other restrictive policies that sort of raise the barrier to entry.

Now we'd be happy to take any questions or comments or suggestions.

DR. NEWHOUSE: I have a couple of suggestions. One is in the analysis of cost. It wasn't clear in the draft you circulated but I think you should use costs in the acute care hospital before allocation. That is conceptually you want to know what costs would have been incurred in the acute care hospital but for the care moving out. So you do not want fixed costs in that comparison.

And my guess is that the unallocated costs are a better

approximation of that than the allocated costs. But you should use your judgment. --

MS. CARTER: So you're talking about the allocation of overhead, not the allocation to Medicare?

DR. NEWHOUSE: Correct.

My second suggestion is on the control group. There was a discussion and, in fact, you alluded to it in your presentation, of using a control group of community hospitals where specialty hospitals are located. I actually think you want two comparison groups. You'd like to look at community hospitals where there's more and where there's fewer specialty hospitals to look at an impact.

MR. MULLER: I think you did an excellent job of laying out the study design.

Going by analogy back to some of our concerns seven or eight years ago about whether we have the right risk adjustment in the managed care plans and whether there's a lot of opportunities by careful case selection to profit handsomely from the Medicare program. I think we should also look at to what extent the specialty hospitals can undermine the whole PPS system because obviously you get it in some part here.

But in a system based on averages the extent to which one can ride below the averages and take off cases that do not -- take cases and aggregate them in a way, as you point out in your analysis, by having this just in three specialties, many of them not having a wider range of services, not having emergency rooms and so forth, a lot of the complexity that goes into a more general setting is obviously not witnessed -- I mean, I shouldn't presume it but it may not be witnessed there. The GAO study showed that as well.

So I'd you to consider commenting on the study as to what extent this moment can, in fact, undermine the whole integrity of the PPS system.

MS. BURKE: I won't repeat it but I, in fact, was going to make the same point that Ralph was going to make. I do want to understand that sort of fundamental question about whether this really does undermine the whole thought as to how we built the PPS system.

But at the risk of repeating yesterday's arguments, I wonder whether there is anything that we will learn here or that we could learn here that would inform us as well on the issues relating to the LTCHs.

There are similar kinds of questions about market analysis, about impact on the community hospitals. And I wondered if there isn't, as we look at both of these issues and build an understanding of the markets in the community hospitals and what has happened in terms of service mix, whether there isn't some benefit sort of both sides looking for some of these issues together and perhaps looking to what extent there are similarities or answers that might be gleaned from either study that would help the other.

MR. PETTENGILL: I think some of the analysis of DRG profitability and case selection within DRGs and that sort of thing would be very relevant to the long term care hospital

problem. By having said that, that's probably the only part where there's sort of a direct parallel. The rest of it, the study population we have to look at here in terms of markets and hospitals, the database in effect, is very different.

DR. WOLTER: I think this was very well put together and certainly it's ambitious when you look at looking at DRGs and the self-referral issues and all of these things.

I think though, that if we get some good information back that this could be very, very helpful. And as you know, I'm very interested in the DRG profitability issue because I think, even aside from the specialty hospital issue within the not-for-profit hospital sector itself lots of decisions around business strategy get made on that basis which are not always driven by what's in the best interest of the services needed by the beneficiary. So I think that could take us in a number of directions.

And then that I would just underscore, I think the whole issue of self-referral is so important and it is a very difficult issue, an emotional issue. We have rules about it in some areas but not in others. But when is it a conflict of interest to be referring to yourself and when is it not? And there are gray areas here. But I think that discussion can be quite valuable.

DR. WAKEFIELD: No rush. Go-ahead.

MR. DURENBERGER: We're on the same plane, go ahead.

DR. WAKEFIELD: You're right, we are on the same plane, it's true. You're not leaving without me, Dave.

You mentioned in the text that you provided us that proponents of specialty hospitals suggest that patient satisfaction is perhaps higher for patients treated in those facilities.

Is there anything that you could access that would give us a sense from national datasets in comparing these hospitals to non-specialty hospitals about the patient satisfaction? Any read that we could get on that?

Because your quality data, as you indicated, are pretty thin in terms of what you're going up to look at. Could you do inpatient satisfaction or is that not going to be an option?

MR. PETTENGILL: That's something we'll have to explore. I hadn't considered that. But certainly, if there are data at CMS, but I'm not sure about that. We'll have to talk to Karen and see what we can dig up.

MR. DURENBERGER: Of course, since I made that crack about being your mother...

DR. WAKEFIELD: People who weren't here yesterday won't understand that.

MR. DURENBERGER: Alan, are you Medicare-eligible yet?

DR. NELSON: Yes.

MR. DURENBERGER: Oh, there's two of us.

I have two suggestions. One of them does go to sort of the heart of the study. But the study is really great and it's really terrific.

One is sort of like a suggestion about focus. And I think as I look over what the specialty hospitals say about themselves, efficiency, quality, satisfaction, innovation, and things like that, that is the same thing that people care about. And so I

just think if the focus of the report, like the very last thing up there, really is on answering the question which is what should communities look like in terms of high quality, innovation, access, choice, a whole variety of things like that.

The other issues, which are the complaints from general hospitals, probably are not necessarily the first choice of priorities by the vast majority of citizens, although they are important to some and they do need to be dealt with.

But if we focus this not just as one group versus another group and who's right and who's wrong and so forth, but just think about it as a community of people and highlight the things that people ought to be concerned about, which are efficiency, quality, satisfaction, innovation, access, choice and so forth, you can still get to the same issue. But I think the report has more meaning to legislators who asked you for it.

The second one is related to that. In the study plan I think the selection of the communities you go to is very important because there are communities in this country that are already starting to deal in some way with this issue not just legislatively.

And in that regard, if you would add to the list of people that you talk to purchasers, particularly large employers. And if you can get beyond the sort of level of frustration that they have when they see this competition going on and they know they're paying for it but they don't understand it, try to understand better as you look at various of these communities what role the purchasers believe, on behalf of employees and all that sort of thing, they could or might be able to play in this whole process. I think it would give us some helpful information.

And I'm assuming the people at the Center for Studying Health System Change, who I know help us out at various times, can be helpful to you in both regards.

MR. HACKBARTH: Anybody else?

Okay, thank you very much.